Healthy Montana Mouths

Referral to Dentist	
Today's Date:	☐ Routine Referral ☒ Immediate Referral
Referring Practice:	Referring Provider:
Referring Provider Fax:	Referring Provider Phone:
Patient name:	Sex: ☐M ☐F DOB:
Parent/guardian Name: _____ Relationship to child: ☐Mother ☐ Father ☐Other _____ Best phone number: _____ Primary language: ☐ English ☐Other Interpreter needed? ☐Yes ☐No	Insurance: ☐ Medicaid ID#_____ ☐ Other insurance_____ ☐ Dental insurance_____ ☐None/Self-pay
Significant medical history:	There are factors that could hinder performing an oral exam, x-rays and/or dental treatment. ☐No ☐Yes (explain)
This child has allergies: ☐No ☐ Yes (please list)	Date of last fluoride varnish application: _____ Fluoride supplement prescribed: ☐ Yes ☐ No
I am the parent/guardian for this child. I consent to this medical provider sharing information about my child with the dentist/dental practice named below. I also consent to the dentist sharing information about my child with this medical provider.	Signature: _____ Date: _____
Dentist/Dental Practice Name:	Phone: _____ Fax: _____
Dental Report to Medical Provider	
Date of appointment(s):	
Treatment provided: ☐ Oral hygiene instruction ☐Prophylaxis ☐Fluoride treatment	☐ Restorative care: ☐ Extractions: ☐ Other:
Summary:	Practice Name and address:
Dentist name:	Dentist signature: Date: